



PRF NEWS

Volume 7, Number 3

Covering Practice and Risk Management Issues for Physicians

Once a Cesarean, Always a Controversy: The Status of VBACs in 2005

BY ELLIOTT K. MAIN, M.D.

It is both fascinating and disconcerting that no widely recognized obstetrical practice in recent memory has gone in and out of favor as rapidly and dramatically as vaginal birth after prior cesarean section (VBAC). In response to nationwide efforts to reduce cesarean section rates, the percentage of successful vaginal births after cesarean section increased from 5 percent to 10 percent in the early 1980s to a peak of 27 percent in 1997. Many hospitals in the Bay Area had VBAC attempt rates approximating 75 percent with a success rate of 75 percent, resulting in a VBAC delivery rate of almost 50 percent. Yet just five years later, VBAC rates had plummeted to 12 percent and have continued to fall. Many smaller hospitals in the Bay Area have stopped offering VBAC altogether. It's impossible to observe this striking reversal in obstetrical practice and not immediately ask "What happened?"

In a sense, the story of VBACs is a cautionary tale illustrating the pitfalls that can occur when attempting to implement the findings of evidence-based medicine. In the 1980s, data appeared from numerous small studies (300-400 patients each) that were uniformly interpreted as showing that there was no difference in complications when VBAC was compared to repeat cesarean sections. Since VBAC was both cheaper and accompanied by less patient discomfort and recovery time, these findings were enthusiastically embraced by both medical leadership and insurance companies and an attempt at vaginal delivery soon became the clinical standard of care for all pregnant women with a prior cesarean section. However, in reality, uterine ruptures were occurring "below the statistical radar screen" at a rate of about one percent—a rate too low to be statistically significant with the relatively small sample sizes typically under investigation. The failure to recognize this complication was a textbook example of a Type II statistical error, i.e.,

the inability to show a difference does not mean that a difference does not exist.

A uterine rupture is one of the worst nightmares in obstetrical practice: in a matter of a few minutes a normally progressing labor can result in a stillbirth or badly damaged surviving infant and a mother with a hysterectomy. If a rupture of the uterus results in complete or near complete placental abruption, the medical team has only about 20 minutes to deliver the baby and have a successful resuscitation. Once the true VBAC risk of uterine rupture was fully appreciated, the American College of Obstetricians and Gynecologists (ACOG) and then the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued guidelines for the implementation of "immediate response" teams that could save a baby and mother from such a catastrophe. The expenses and implied liability of maintaining an "immediate response" team led to an immediate reduction in hospitals

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offering VBACs. Furthermore, accurate informed consent meant that mothers needed to be told of the 1/100 chance that their baby might suffer major morbidity or mortality if a VBAC attempt was associated with uterine rupture. As a result, the popularity of VBAC plummeted.

CAN VBAC BE PERFORMED MORE SAFELY?

By focusing on reacting quickly to a uterine rupture once it occurs, the ACOG and JCAHO recommendations for increasing the safety of VBAC were appro-

that is anything but "plain vanilla." Histories of any type of vertical incision, unknown incision, or prior cesarean for second stage cephalopelvic disproportion (CPD) are essentially contraindications. On the other hand, a prior vaginal delivery is a good prognostic sign. Equally importantly, the attitude toward labor management should be that absolutely nothing is forced. Induction with an unfavorable cervix is a major risk. Any form of prostaglandin is contraindicated. When we reviewed our experience with uterine ruptures at California Pacific Medical Center (CPMC) in 2001, fully 80 percent were related to labor

risks. At CPMC, other obstetrical complications such as uterine atony and placenta accreta have led to more cesarean hysterectomies following elective repeat cesareans than we have experienced with VBAC. Furthermore, although not generally life-threatening, there clearly is more neonatal respiratory morbidity with repeat cesareans than with VBAC. Our current recommendations for VBACs can be summarized as follows:

- ▶ Provide full informed consent. Most hospitals have forms that describe the risks and benefits of both VBAC and Repeat Cesarean Section.
- ▶ Adequately screen for obstetrical contraindications.
- ▶ Do not induce labor unless the candidate is ideal, such as a favorable cervix and a history of vaginal delivery.
- ▶ Manage the labor in the least traumatic manner possible.
- ▶ Only perform a VBAC in a labor unit able to respond immediately to an emergency.

More recent research suggests that the safety of VBAC can be significantly enhanced by improving the screening of potential candidates for VBAC and then managing labor in a way that minimizes the chance that a uterine rupture will occur.

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BETTER CANDIDATES/ BETTER LABOR MANAGEMENT

In deciding whether a patient is a good candidate for VBAC, one should think twice about a history

of induction or prolonged (>8 hrs) augmentations with standard oxytocin regimens. Beginning in January 2002, we instituted a policy of not inducing labors without a history of a prior vaginal delivery and only gently augmenting labors. This has resulted in a 50 percent reduction in our VBAC attempt rate, but we have not had a single uterine rupture during any of these almost 400 labors.

NO RISK-FREE CHOICES

Like all clinical strategies in obstetrics, no choice is without

CONCLUSIONS

Although VBAC is not for everyone, it should not be eliminated as a valid and useful clinical strategy. In thoughtfully selected patients using cautious labor management we have shown that it can be a safe and effective technique. ■



DOES THIS NEWSLETTER MEET YOUR NEEDS?

PRF wants to be sure that this newsletter is relevant to Insureds, so please offer suggestions for risk management topics that should be covered or any specific ideas for articles. Within your practice what areas of concern should PRF News be addressing? Are there any web sites or other resources that are particularly useful in your practice? Would you like to submit an article for publication in PRF News? Please call the PRF office at (415) 921-0498 or send an e-mail to June Riley at june@prfrg.com with your feedback or other information. ■

Code Green: What Is It and How Can It Help You?

BY JUNE RILEY, MBA

For several years, PRF has been supporting a risk management approach that encourages the early resolution of adverse medical outcomes. We call this unique policy “Code Green.” For those PRF members who are unfamiliar with the term, **Code Green is a PRF program designed to “make the patient whole again” subsequent to an untoward outcome arising out of medical treatment or procedure.** The underlying objectives of Code Green are to maintain a good doctor-patient relationship while providing the patient with the best medical care possible, even when things don’t go as planned. Code Green in no way implies an admission of “guilt” or the acceptance of “blame” on the part of the treating physician. Code Green is a real and tangible way of saying to the patient:

- “I’m sorry that this happened to you.”
- “How has this event affected you?” i.e., “What inconvenience or expense have you suffered as a result of this event?”
- “This is what I can do to help.”

The following two examples illustrate situations where Code Green can be applied:

- **A medical procedure is unsuccessful or incomplete.** A PRF physician performs a circumcision on a newborn. Weeks later it is determined that the procedure needs to be redone.

The physician could “Code Green” the incident by offering to waive the fee for the second procedure while reimbursing the parents for any out-of-pocket expenses incurred as a result of repeating the procedure. If the parents were to choose to have another physician perform the second procedure, “Code Green” would suggest that the original physician offer to pay for that procedure.

- **Known complications arise out of a surgical procedure.** A patient suffers a

the surgery and the complication.

Code Green could be applied in other cases, such as when:

- a patient feels a delay in diagnosis may have caused them harm
- a patient has an otherwise successful procedure save for a sponge that is inadvertently left behind
- an oral surgeon accidentally extracts the wrong tooth

The key to successful implementation of Code Green is to make every effort to maintain a positive doctor-patient relation-

If you feel that you have a situation with one of your patients that Code Green could help resolve, call the PRF office at (415) 921-0498, explain the circumstances, and staff will guide you through the process.

perforation during a surgical procedure. The perforation is properly diagnosed and repaired, but the complication prolongs the patient’s recovery time. The surgeon could “Code Green” this incident by offering to reimburse the patient for missed income due to the prolonged recovery, offering to pay for home health care, and/or offering to reimburse the patient for out-of-pocket expenses associated with

ship. **If you feel that you have a situation with one of your patients that Code Green could help resolve, call the PRF office at (415) 921-0498, explain the circumstances, and staff will guide you through the process.** If you have questions about Code Green in general and would like a more in-depth explanation of the process for future reference, please call the PRF office and staff will gladly answer any questions you may have. ■



ANNUAL MEETING IS SET FOR APRIL

Every April PRF holds its Annual General Membership Meeting, which is a great opportunity to learn more about PRF and to meet the members of the Board of Directors and the staff. The more you know about PRF, the more PRF can help you to manage your risk. Meeting details will be announced well in advance, so please make it a point to come to the 2005 Annual General Membership Meeting. ■



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The Expanding Role of Physician Assistants

BY JUNE RILEY, MBA

Although the first graduates of a formal Physician Assistant (PA) baccalaureate degree program in the United States were mostly military corpsmen who had served in Viet Nam in the late 1960s, PAs have been recently identified as one of the fastest growing health occupations in the nation. While 60,000 PAs currently manage over 200 million patient visits a year, the Bureau of Labor Statistics projects that the number of PAs in this country will approach 100,000 by the year 2010 as healthcare institutions and physicians anticipate the health care needs of an aging baby boomer population.

SCOPE OF PRACTICE

As defined by the U.S. Department of Labor, a physician assistant is a graduate of an accredited educational program who, under the supervision of a physician, can provide healthcare services typically performed by a physician. Depending on individual state law, PAs can:

- conduct physical exams
- diagnose and treat illnesses
- order and interpret tests
- counsel on preventive health care
- assist in surgery
- (in virtually all states) write prescriptions

However, physicians may delegate to PAs only those medical duties that are within the physician's scope of practice and the PA's training and experience.

EMPLOYING A PHYSICIAN ASSISTANT

For physicians interested in exploring the possibility of

employing a PA, the American Association of Physician Assistants website (www.aapa.org) offers comprehensive information and publications that include:

- *Hiring a Physician Assistant*
- *Physician Assistants and Hospital Practice*
- *Contracts & Contracts: An Employment Guide for PAs*

ISSUES OF CONCERN

The three most common concerns of physicians contemplating hiring a PA are questions relating to costs, billing, and professional liability.

- **Cost:** In California, the average Physician Assistant salary is approximately \$80,000 a year. This expense must be weighed against the benefits of allowing the physician to concentrate on treating patients who require more advanced knowledge and expertise.

- **Billing:** Although PAs can bill Medicare and commercial insurers for their medical services, billing regulations may vary from insurer to insurer and may also vary for the same insurer depending on the type of service performed.

- **Professional liability:** While PAs are required to have their own medical malpractice insurance, the premiums are markedly lower than those paid by physicians. In the experience of PRF, the risk exposure of PAs is relatively low, although in the event a claim is filed, the supervising physician will most likely be named and assume the liability. ■